MEDICAL RECORD - TOBACCO CESSATION DOCUMENTATION
For use of this form see MEDCOM Circular 40-12

TREATMENT FACILITY | DATE

SECTION I - VITAL SIGNS *(Completed by Technician)*

TIME: _____ BP: _____ PULSE: _____ RESP: _____ TEMP: _____ HT: _____ WT: _____

ALLERGY: _____ MEDICATIONS: _____

SECTION II - PATIENT ASSESSMENT *(Completed by Patient/reviewed by Provider)*

1. At what age did you start using tobacco? _____

2. What type(s) and amount(s) of tobacco do you use?

TYPE(S)	YES	NO	AMOUNT(S)	PER DAY	PER MONTH
a. Cigarette			Packs		
b. Pipe			Bowls		
c. Cigar			Cigars		
d. Snuff			Cans		
e. Chew			Pouch		

3. How soon after you wake up do you use tobacco? ☐ After 30 minutes ☐ Within 30 minutes

4. Have you quit before? ☐ Yes ☐ No

5. How many times have you quit before? _____

6. What was the longest period you were able to quit? _____

7. What caused you to start using tobacco again?

8. Did you use any of the following to help you quit? ☐ Patch ☐ Gum ☐ Zyban ☐ Inhaler
☐ Nasal Spray ☐ Individual Counseling ☐ Formal Program ☐ Other _____

9. Why do you want to quit tobacco use? ☐ Financial Saving ☐ Breathing Problems ☐ Heart Problems
☐ Fear of Cancer ☐ Family/Social Pressure ☐ Other Issues _____

10. What support do you have available to help you quit tobacco use? ☐ Family ☐ Friends
☐ Work ☐ Other _____

11. What type of program do you believe would help you the most?
☐ Group ☐ One on One ☐ Counseling ☐ Self Quit

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

(Patient's Signature/Date)

SECTION III - MEDICAL HISTORY AND PHYSICAL ASSESSMENT *(Completed by Health Care Provider)*

MEDICAL HISTORY

MEDICATIONS REVIEWED: ☐ Yes ☐ No ALLERGIES REVIEWED: ☐ Yes ☐ No LMP: _____

ETOH: ☐ Yes ☐ No ☐ Cut Down ☐ Annoyed ☐ Guilty ☐ Eye opener

During the past month have you been bothered by: Feeling down, depressed, or hopeless ☐ Yes ☐ No

Little interest or pleasure in doing things ☐ Yes ☐ No

PMH affecting use of NRT/Bupropion:

PRECAUTIONS/CONTRAINDICATIONS	YES	NO	PRECAUTIONS/CONTRAINDICATIONS	YES	NO
HEAD TRAUMA			MOOD DISORDER		
SEIZURES			POLYCYTHEMIA		
CHRONIC PAIN DISORDER			DIABETES		
LIVER DISEASE			CARDIOVASCULAR DISEASE		
HYPERTHYROIDISM			**COMPLICATIONS OF TOBACCO USE**	YES	NO
KIDNEY DISEASE			CHRONIC OBSTRUCTIVE PULMONARY DZ		
PREGNANCY			ASTHMA		
LACTATING			CORONARY ARTERY DISEASE		
SUBSTANCE ABUSE			CANCER		
EATING DISORDER			ERECTILE DYSFUNCTION		
POST TRAUMATIC STRESS DISORDER			PERIPHERAL VASCULAR DISEASE		
ANXIETY			OTHER		

Physical Assessment:

SECTION IV - ASSESSMENT *(Completed by Health Care Provider)*

PRIMARY ASSESSMENT: Tobacco Cessation V65.49 4 (DOD unique extender) ICD - 9-CM 305.1

SECTION V - ACTION PLAN *(Completed by Health Care Provider)*

1. MEDICATIONS: NRT Prescribed? ☐ YES ☐ NO

   ☐ Transdermal Nicotine (Contraindicated in Pregnancy) ☐ 7 Mg x ____ weeks ☐ 14 Mg x ____ weeks

   ☐ 21 Mg x ____ weeks ☐ ____ Mg x ____ weeks

   ☐ Polacrilex Nicotine PRN

   ☐ Other: ____ Bupropion SR 150 mg ____ po,qd x _____ days, then _____ bid.

2. Tobacco Cessation Counseling:

   ☐ Patient congratulated on decision to quit tobacco usage: Quit Date _____

   ☐ Patient advised to avoid all tobacco products during NRT.

   ☐ Tobacco cessation benefits reviewed.

   ☐ Patient advised of withdrawal symptoms.

   ☐ Patient concerns and support systems addressed.

   ☐ Patient advised to take medication as directed.

   ☐ Educational materials given to patient.

3. What type of tobacco cessation program would you like to participate in?

   ☐ Formal ☐ Group ☐ Behavior Modification ☐ One On One ☐ Self Quit Program

4. Referral To:

   ☐ Stress Management ☐ Dietary ☐ Other: _____

5. Follow-Up Appointment within 2 weeks: _____

_____

(Provider's Signature/Date)